(11) Payments for Inpatient Psychiatric Facility Services for Individuals Under 22 Years of Age

(A) Covered inpatient psychiatric facility services for individuals under 22 years of age provided in psychiatric hospitals are paid in accordance with the provisions described in Attachment 4.19-A

(B) Covered inpatient psychiatric facility services for individuals under 22 years of age provided in licensed psychiatric resident treatment facilities (PRTFs) are paid in accordance with the following:

(1) The PRTFs shall be paid a fixed per diem rate of $230 which shall be adjusted upward each biennium by 2.22 percent or the usual and customary charge, if less. The payments shall not exceed prevailing charges in the locality for comparable services provided under comparable circumstances. The fixed rate (upper limit) is the state's best estimate of the reasonable and adequate cost of providing the services. This rate is.determined in the following manner:

(a) Facilities that provide services that meet the criteria for PRTFs are requested to submit their actual costs for covered services. These costs shall include all care and treatment, staffing, ancillary services (excluding drugs), capital, and room and board costs.

(b) The actual costs submitted by the facilities are compared to the costs estimated to operate a model PRTF. The costs of the model facility and current facilities are analyzed on the basis of their being reasonable and adequate to meet the costs which would be incurred in order to provide quality services in an economic and efficient manner.

(c) From this analysis and a consideration of the comments from the facilities, a uniform per diem rate is established for all participating facilities.

(d) This per diem rate is then adjusted for inflation by 2.22 percent biennium. This inflation rate is based upon the historic rate of inflation as applied to these facilities and their necessary increases in costs of providing the services.

(2) The fixed rate or usual and customary charge, if less, covers total facility costs for PRTF services including the following: all care and treatment costs, staffing, costs for ancillary services (except drugs), capital costs, and room and board costs. The rate is established to be fair and adequate compensation for services provided to Medicaid beneficiaries.

Attachment 4.19-A
Exhibit A

CABINET FOR HUMAN RESOURCES
TITLE XIX
INPATIENT HOSPITAL
REIMBURSEMENT MANUAL

GENERAL POLICIES AND GUIDELINES

Cabinet for Human Resources
275 East Main Street
Frankfort, Kentucky 40621

TN # 83-3
Supersedes
TN # 82-26

Approval
Date 6-6-83

Effective
Date 1/1/83

Department for Medicaid Services
General Policies and Guidelines

Hospitals

TABLE OF CONTENTS

Kentucky Medical Assistance Program
General Policies and Guidelines

100. INTRODUCTION:

A cost-related, prospective payment system for hospitals providing inpatient services for Title XIX (Medicaid) recipients, to be reimbursed under the Kentucky Medical Assistance Program (Program) of the Department for Medicaid Services (Department), is presented in this manual. If not otherwise specified, this system utilizes allowable cost principles of the Title XVIII (Medicare) Program. This payment method is designed to achieve three major objectives: 1) to assure that needed inpatient hospital care is available for eligible recipients and indirectly to promote the availability of such care for the general public, 2) to assure Program control and cost containment consistent with the public interest, and 3) to provide an incentive for efficient management.

Under this system, payment will be made to facilities on a prospectively determined basis for the total cost of inpatient care with no year-end cost settlement required. The basis of this prospective payment is the most recent Medicaid cost report (HCFA-2552) available as of December 1 of each year, trended to the beginning of the rate year and indexed for inflationary cost increases which may occur in the prospective year.

In addition, a maximum upper limit will be established on all inpatient operating costs exclusive of capital costs, and professional component costs. For purposes of applying an upper limit, hospitals will be peer grouped according to bed size with allowances made in recognition of hospitals serving a disproportionate number of poor

patients. Another feature of the prospective system is a minimum occupancy factor by peer group applied to operating costs and to capital costs attributable to the Medicaid program.

For universal rate years beginning prior to January 1, 1985, the prospective rate will be adjusted to the extent that an audited cost report alters the cost basis for the prospective rate and/or the projected inflation index utilized in setting the individual rate is different from actual inflation as later determined by Data Resources, Inc. and reported by their index.

For universal rate years beginning on or after January 1, 1985, if unaudited data is utilized to establish the universal rate, the rate will be revised when the audited cost report is received from the fiscal intermediary.

The payment system is designed to provide for equitable payment levels for the various peer groups of hospitals, and will directly result in the use of rates that are reasonable and adequate for efficiently, economically operated hospitals while providing services in conformity with applicable state and federal laws, regulations, and quality and safety standards.

Department for Medicaid Services
General Policies and Guidelines

Hospitals

100A. SPECIAL PAYMENT RATES AND UPPER LIMITS PERIOD

For the period beginning on April 1, 1993, and ending on June 30, 1993, acute care and rehabilitation hospital payment rates and upper limits shall be the same rates (including necessary adjustments for audits or other purposes) and upper limits as the rates and upper limits in effect for the rate period of January 1, 1992, through December 31, 1992. This section shall be effective with regard to services provided on or after April 1, 1993.

101. PROSPECTIVE RATE COMPUTATION:

The prospective system is based on a universal rate year which is set for all hospitals using the most recent cost report data available as of December 1 of each year, trended to the beginning of the rate year and indexed (adjusted for inflation) for the prospective rate year. Rates based on unaudited data shall be revised when the audited cost report is received from the fiscal intermediary. Prospective rates include both inpatient routine and inpatient ancillary costs and are established taking into account the following factors:

(a) Allowable Medicaid inpatient cost and Medicaid inpatient days based on Medicare cost finding principles shall be utilized. Medicaid inpatient capital cost (as defined in b. below) and Medicaid inpatient professional component cost are subtracted from allowable Medicaid inpatient cost and the result is trended to the beginning of the rate year. The Medicaid inpatient capital cost is later used in determining a capital cost per

diem. The Medicaid inpatient professional component costs shall be trended to the beginning of the rate year separately from the inpatient costs.

(b) Medicaid inpatient capital costs based on Medicare cost finding principles shall be utilized except that Medicaid inpatient building and fixtures depreciation cost is defined as sixty-five percent (65%) of the amount reported for building and fixtures.

(c) Allowable Medicaid inpatient cost and professional component costs, excluding return on equity capital, and those fixed costs associated with capital expenses, shall be increased by the hospital inflation index to project current year inpatient operating cost.

(d) Medicaid inpatient return on equity capital shall be added to the projected Medicaid inpatient operating cost as an allowable cost.

(e) A Medicaid inpatient operating cost per diem is computed utilizing the Medicaid inpatient operating cost and Medicaid inpatient days.

(f) An upper limit shall be established on inpatient operating costs at the weighted median inpatient cost per diem for hospitals in each peer group, except as otherwise specified in Section 102. For purposes of applying an upper limit, hospitals shall be peer grouped according to bed size. The peer groupings shall be: 0-50 beds, 51-100 beds, 101-200 beds, 201-400 beds, and 401 beds and up. Peer grouping shall be based on the number of Medicaid certified hospital beds at the time of rate setting.

Department for Medicaid Services
General Policies and Guidelines

Hospitals

(g) A Medicaid inpatient capital cost per diem is computed using Medicaid inpatient capital cost and Medicaid inpatient days. This inpatient capital cost per diem is adjusted by minimum occupancy levels if necessary. A sixty percent (60%) occupancy factor shall apply to facilities with 100 or fewer beds. A seventy-five percent (75%) occupancy factor shall apply to facilities with 101 or more beds.

(h) A Medicaid inpatient professional component cost per diem is computed utilizing the Medicaid inpatient professional component costs and Medicaid inpatient days.

(i) The prospective inpatient rate is the sum of the inpatient operating cost per diem, the inpatient capital cost per diem, and the professional component per diem.